BlueChoice® New England†

Anthem

State of NH Summary of Benefits
Troopers POS

*This is only a brief summary of your coverage. Benefits apply when care is **medically necessary**. Services are covered up to the Maximum Allowable Benefit (MAB). Network providers agree to accept the MAB as payment in full. However, if you receive services from a non-network provider, under Self Referred benefits, it is your responsibility to pay the difference between the MAB and the provider's charge.*

Service Received	Your Share of the Cost	
Preventive Care	**In-Network Benefits**	**Out-of-Network Benefits∩**
• Immunization (including travel), lead screening, PSA (prostate screening)	No charge	Covered up to MAB
• Routine physical exam and well baby care • Routine hearing screening (*through age 18)* *See "Other Services" for additional Preventive Care information*	No charge	Subject to deductible and coinsurance: Individual: $150 deductible per member per calendar year and 20% coinsurance up to $750 per member Family: $450 per family per calendar year and 20% coinsurance up to $2,250 per family per calendar year Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details. Call 1-800-531-4450 to precertify.
Other Outpatient Care • Medical exam, family planning and office surgery • Treatment for surgical and non-surgical TMJ *(excluding appliances and orthodontic treatment)* • Infertility diagnosis and treatment	$10 PCP/$20 Specialist copay	
• Lab, X-ray and ultrasound • Allergy treatments and injections • Short term rehabilitative therapy- physical, cardiac, occupational, or speech *(Unlimited in-network; $3,000 per calendar year out-of-network)* • CT scan and MRI, outpatient facility fees • Surgery in hospital outpatient department or ambulatory surgery center	No charge	
Inpatient Care (as a bed patient in an acute care hospital) • Semi-private room and board . . . . . . • Physician in-hospital care, surgery, delivery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy	No charge	
Skilled Nursing Facility and Rehabilitation Facility Care *(Limited to 30 days combined maximum per member per calendar year)*θ	No charge	
Other Services • Routine vision exam – birth through age 18 *(one exam every year)* • Routine vision exam – age 19 and over *(one exam every two years)* • Chiropractic visit *(limited to 20 visits per member per calendar year)* • Hearing aids – birth to age 18 • Nutritional Counseling – *(If billed as an office visit, service will be subject to an office visit copay, 3 visits per member per calendar year, unlimited for diabetes or organic disease)* • OB/GYN care (performed by an OB/GYN provider) - Exam (well women exam 1 per year) - Maternity care (routine prenatal, delivery and postpartum)	No charge	
• Mammogram and Pap smear	No charge	Covered up to MAB
Emergency Room (ER) Visit • **ER charge** ***(waived if admitted or referral from PCP/Treating physician)***	$50 copay	$50 copay
• ER physician fee	No Charge	No Charge
Ambulance (medically necessary emergency transport only)	No Charge	No Charge
Durable Medical Equipment (DME) and External Prosthetic Devices *(unlimited)*	No charge	$100 deductible then 20% Coinsurance

θ Any combination of benefits from either column count toward this maximum.

∩ Services are covered up to the MAB. Out of network providers may bill you for amounts that exceed the MAB.

For these services, ALL care must be authorized in advance by Anthem Behavioral Health (ABH) at 1-800-228-5975. You will pay less if you utilize a network provider.

Mental Health and Substance Abuse (MH/SA)	Network Benefits	Out-of-Network Benefits∩
• Outpatient services - Visit/consultation	No Charge	Individual: $150 deductible per member per calendar year and 20% coinsurance up to $750 per member Family: $450 per family per calendar year and 20% coinsurance up to $2,250 per family per calendar year Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details. Call 1-800-531-4450 to precertify.
• Inpatient services - Semi-private room & board - MH/SA physician visit	No charge	
Substance Abuse (SA) • Outpatient services - Visit/consultation	No Charge	
• Inpatient services - Semi-private room & board - MH/SA physician visit *(Inpatient and outpatient substance abuse benefits are limited to $5,000 per member per calendar year and $10,000 lifetime maximum per member. This limit is a combined in-network and out-of-network limit.)*	No charge	

Prescription Drugs

Prescription drug benefits are administered by Caremark. For assistance with prescription drug benefit inquiries, call:

- Local Government Center: 1-800-527-5001 or Caremark: 1-888-726-1630

Maximums (Copays, DME Deductible and Coinsurance)

	Network Benefits	Out-of-Network Benefits∩
• Individual Out-Of Pocket Maximum	$500 per person per calendar year	$900 per person per calendar year
• Family Out-of-Pocket Maximum	$1,000 per family per calendar year	$2,700 per family per calendar year
• Life Time Benefit Maximum	Unlimited	Unlimited

Other

- Health Education Reimbursement: $150 per family per calendar year
- Fitness Equipment Reimbursement: N/A
- Eyewear benefits: N/A

Exclusions and Limitations

The services listed below are not covered by this plan. Please review your Benefit Booklet for complete details on exclusions and limitations.

Services Not Covered

•Any service that is not medically necessary • Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met) • Claims for services received more than 12 months ago • Complementary and Alternative Therapies/ Medicine • Cosmetic surgery • Custodial or convalescent care • Educational testing and therapy • Experimental and/or investigational services • Hospitalization for conditions that are not covered • Human organ transplants other than those listed in the Subscriber Certificate as covered benefits • Mental health services which do not usually result in favorable modification through short-term therapy • Miscellaneous devices, materials, and supplies, including, but not limited to, breast pump, hearing aids (except for children under 19) , dentures and support devices for the feet and corrective shoes • Permanent dental restoration, orthognathic and most oral surgery • Personal comfort items • Radial keratotomy or other surgery to correct vision • Routine podiatry • Services covered by government programs to the extent permitted by law • Services for work-related illness or injury • Sex changes •Eye glasses and contact lenses (except after cataract surgery)

Anthem Blue Cross and Blue Shield has the right to recover its costs for care of:

• Injuries which are the responsibility of other parties • Services for which another insurance carrier or Medicare is primary • Services related to illegal conduct

This is only a brief summary of your coverage.

This summary of benefits is not a contract. It is a general description of the benefits and exclusions of this plan. Complete information about all benefits, limitations and exclusions is in the Benefit Booklet, which is available upon request. If you need further information, call Customer Service at 1-800-933-8415.

∩ Services are covered up to the MAB. Out of network providers may bill you for amounts that exceed the MAB.

† BlueChoice New England is administered by Anthem Blue Cross and Blue Shield and underwritten by Matthew Thornton Health Plan